Appendix Q

Sexual Offense Evidence Collection Kit Instruction Sheets, including Patient Information Form and Medical Record Sexual Assault Form

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SEXUAL OFFENSE EVIDENCE COLLECTION KIT

INSTRUCTION SHEET

NOTE:
This kit is designed to assist in the uniform collection of evidentiary specimens in any case when the crime/incident involved is a sexual assault. Although the completion of each appropriate step is requested, it is acknowledged that the examiner may elect not to complete one or more steps, based upon a consideration of the physical and/or emotional well-being and preference of the patient. It must be acknowledged that a patient has the right to refuse one or more of the individual steps without relinquishing the right to have evidence collected.

Each step in this kit is designed for one of two purposes. The first is to recover potentially valuable physical evidence that will be useful in any subsequent investigation and legal proceeding to identify the perpetrator of the alleged assault (through forensic DNA analysis, for instance) and/or to verify the nature and circumstances of the alleged assault. The type of evidence often detected includes hairs, saliva, semen, spermatozoa, blood, fibers, plant material, soil and other debris that may have been transferred from the perpetrator's clothing or personal effects, or from the scene of the alleged assault. The other steps are intended to collect evidence that will be used as a reference standard (controls from the alleged victim). Each step is noted as either "*Evidence Collection*" or "*Control Sample*".

This kit contains material sufficient for the collection of evidence from ONE subject (male or female). Use a separate kit for each person.

This kit MAY be used to collect evidence from a suspect. If used for this purpose, follow steps 3, 4, 6, 7, 8, 9, 11, and 12. Substitute suspect's name for victim's name in each step.

The hospital is requested not to analyze any of the specimens/evidence collected in this kit.

Refer to NYS Department of Health Sexual Offense Evidence Collection Protocol** for further information concerning the examination of victims of sexual assault. Included in this kit are the Medical Record Sexual Assault form, Body Diagrams, Authorization for Release of Information and Evidence to Law Enforcement form, and Patient Information form as provided by NYS Dept. of Health. The forms are provided for hospital records and are NOT to be included in the completed, sealed kit. Follow the instructions on the forms to determine distribution. In addition, enclosed in the kit is a NYS Crime Victims Board Claim Form which should be given to the victim. Do not include the CVB Claim Form in the sealed kit.

INSTRUCTIONS

STEP 1 ORAL SWABS AND SMEARS *Evidence Collection*

NOTE:
Do not stain or chemically fix smears. Do not moisten swabs prior to sample collection. Upon completion of this step, ask patient to thoroughly rinse mouth with water.

A. Remove all items from envelope. Using both swabs simultaneously, carefully swab the patient's mouth and gum pockets. Using both swabs, prepare two smears. Allow both swabs and smears to AIR DRY.

B. When dry, place smears in slide mailer marked "Oral" and fill out label on mailer. DO NOT DISCARD EITHER SWAB. Place swabs in swab box marked "Oral", and replace both mailer and box in the envelope. Seal and fill out all information requested on envelope.

STEP 2 TRACE EVIDENCE *Evidence Collection*

To minimize the loss of evidence, the patient should disrobe over a large piece of examination table paper, preferably in the presence of the examiner. Carefully fold paper and place it into a paper bag (not provided) and seal the bag. Label the bag with patient's name. Give bag to investigating police officer. If police officer is not present, store sealed bag with the Sexual Offense Evidence Collection kit in a secured refrigerated area.

STEP 3 CLOTHING AND UNDERWEAR (collect all clothing unless patient objects) *Evidence Collection*
Wet or damp clothing should be air dried before packaging. Do not cut through any existing holes, rips, or stains in patient's clothing.

** Refers to the New York State Department of Health Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault.

A. Patient's underwear should be collected and placed within the paper bag provided. Fill out label and seal bag. Other clothing worn at the time of the assault should be assessed carefully for potential evidentiary value such as stains, tears, debris or foreign matter. Taking clothing from patient unnecessarily may cause distress to patient. Ensure patient has access to other clothing before taking.

B. Do not shake clothing, as microscopic evidence may be lost. Place each item into a SEPARATE paper bag (not provided). Label with patient's name and type of item and tape bag shut.

C. If patient has changed clothes after assault, ask if it is possible for the patient to either bring the clothing in to the hospital to be kept with the kit, or, if the patient intends to release the kit to law enforcement, to bring the clothing to the law enforcement agency handling the investigation. Patient should be instructed to package each piece of clothing individually.

STEP 4 DEBRIS COLLECTION *Evidence Collection*

Remove paper towel from Debris Collection envelope. Unfold and place on a flat surface. Collect any foreign material found on patient's body (leaves, fibers, glass, hair etc.), and place in center of paper towel. Refold in manner to retain debris and return to envelope. Seal and fill out information requested on envelope.

STEP 5 DRIED SECRETIONS AND/OR BITE MARKS *Evidence Collection*

A. If dried secretion stains and/or bite marks are found, moisten both swabs with 1-2 drops of water. Using both swabs simultaneously, carefully swab the area of the stain. Allow both swabs to AIR DRY. DO NOT DISCARD EITHER SWAB.

B. When dry, place both swabs in swab box marked "Dried Secretions and/or Bite Marks", label box as to what area of the body was swabbed, why that particular area was swabbed, indicate if it is a suspected saliva or semen stain, and replace in envelope. Seal and fill out all information requested on the envelope. If additional dried secretion specimens are collected, use the second set of swabs and box provided. If still more swabs and boxes are needed, you may use standard hospital swabs and use plain white stationery envelopes in lieu of the boxes.

STEP 6 FINGERNAIL SCRAPINGS *Evidence Collection*

Remove both paper towels and scraper from envelope.

A. Left hand - Unfold one towel and place on flat surface. Hold each finger over towel when scraping so that any debris present will fall onto towel. After all fingers on left hand are done, place scraper in center of towel. Refold towel to retain debris and scraper. Tape closed and mark "L" on towel.

B. Right hand - Follow same procedure used for left hand. Mark towel "R". Return both towels to the envelope. Seal and fill out all information requested on envelope.

STEP 7 PULLED HEAD HAIRS *Control Sample*

Note:
Pulling hair standards for evidence collection is considered by many to be very traumatic to the victims of sexual assault. The examiner must use their professional judgment regarding whether or not to complete this step, based upon the physical and/or emotional well-being and the preference of the patient.

Using thumb and forefinger, not forceps, PULL, do not cut, 5 hairs from each of the following scalp locations (for a total of 25 hairs): center, front, back, left side, right side. Place in envelope and seal. Fill out all information requested on the envelope.

STEP 8 PUBIC HAIR COMBINGS *Evidence Collection*

A. Remove paper towel and place under patient's genital area. Using the comb provided, comb pubic hair in downward strokes so that any loose hairs/debris will fall onto paper towel.
To reduce trauma and embarrassment, and increase their sense of control, the patient may prefer to do the combing.

B. Carefully remove towel. Place comb in center and refold in manner to retain comb and any evidence present. Return to envelope and seal. Fill out information requested on envelope.

C. If pubic hair combings are collected, it is highly recommended that there be a pulled pubic hair control sample (see Step 9).

STEP 9 PULLED PUBIC HAIRS *Control Sample*

Note:
Pulling hair standards for evidence collection is considered by many to be very traumatic to victims of sexual assault. The examiner must use their professional judgment regarding whether or not to complete this step, based upon the physical and/or emotional well-being and preference of the patient. The patient may feel more comfortable pulling these hairs personally.

Using thumb and forefinger, not forceps, PULL, do not cut, 15 full length hairs from various areas of the pubic region. Place in envelope and seal. Fill out all information requested on envelope.

STEP 10 ANAL SWABS AND SMEARS *Evidence Collection*

NOTE:
Do not stain or chemically fix smears. Swabs may be moistened with distilled water prior to collection. Take special care not to contaminate the patient's anal area with debris from the vaginal area.

A. Remove all items from envelope. Using two swabs simultaneously, carefully swab the anus. (Peri-anal stains should be collected as "Dried Secretions" as in STEP 5). Using both swabs, prepare two smears. Allow both swabs and smears to AIR DRY.

B. When swabs and smears are dry, place swabs in the swab box marked "Anal". Place smears in the slide mailer marked "ANAL". Fill out label on mailer and replace both in the envelope. Seal and fill out all information requested on the envelope.

STEP 11 VAGINAL/PENILE SWABS AND SMEARS *Evidence Collection*

Note:
Do not stain or chemically fix smears. Do not moisten swabs prior to sample collection. Take special care not to contaminate the patient's vaginal area with any debris from the anal area.

It is generally unnecessary to use a speculum when evaluating injuries and collecting specimens in a prepubescent or young adolescent female. NEVER USE AN ADULT SIZE SPECULUM WHEN EXAMINING THESE PATIENTS. Even a pediatric speculum may cause further trauma. Specimens for culture and forensic analysis may be obtained by using a glass eyedropper or cotton-tipped applicator. In prepubescent children, a vaginal - not cervical - specimen is appropriate for STD culture. In cases where extensive injury or foreign bodies cannot be ruled out, the exam might cause further trauma to the child, or the child is too distressed to cooperate for the exam, an Examination Under Anesthesia (EUA) is recommended.

A. Remove all items from envelope. Using two swabs simultaneously, carefully swab the vaginal vault/penis. Allow both swabs to AIR DRY.

B. DO NOT DISCARD EITHER SWAB. When dry, place in swab box marked "Vaginal/Penile - DNA".

C. Using the two additional swabs provided, repeat the swabbing procedure. Prepare two smears on the slides provided and allow to AIR DRY. When slides are dry, place them in slide mailer marked "VAGINAL/PENILE" and tape shut. Fill out label on mailer and replace in envelope. DO NOT DISCARD EITHER SWAB. When swabs are dry, place in swab box marked "VAGINAL/PENILE". Replace boxes in envelope. Seal and fill out all information on envelope.

STEP 12 BUCCAL SPECIMEN *Control Sample*

A. Instruct the patient to rinse the inside of mouth with water, using vigorous swishing.

B. Using the special swab from the envelope marked "Buccal Specimen", collect a specimen by swabbing with a scrubbing motion between the cheek and gums on both sides of the mouth. To assure a sufficient sample the swab should be applied in a scrubbing motion for 5 to 10 seconds.

C. Allow the swab to AIR DRY. When dry, place swab in box provided.

D. Replace the swab box in the envelope. Seal and fill out all information requested on the envelope.

FINAL INSTRUCTIONS:

1. Make sure each envelope used contains all requested items and information. Envelopes which were NOT used should bear a mark in the "NO" box next to the "Was sample collected ?" line.

2. Return all evidence envelopes and instruction sheet to the kit box. Remove the Police Evidence Seal from the box. If photographs were taken, do not include them in the kit. Include photos in the patient's medical record or, if an investigating officer is present, give the photos to the officer.

3. Initial the Police Evidence Seal and use it to seal the box.

4. Fill out information requested on top of box in space provided for Hospital Personnel.

5. Give sealed kit and clothing bags to the investigating officer. If officer is not present, place sealed kit in a secure and refrigerated area, in accordance with established protocol. Just as it is the responsibility of each facility to properly collect evidence in sexual assault cases, it is also their responsibility to ensure that evidence is properly maintained, and the chain of custody is documented. N.Y.S.P.H.L. requires that evidence be secured in a refrigerated area for 30 days.

APPENDIX Q - 2

Patient information form
Formulario de informacion sobre el paciente

Patient Name/Nombre y apellido del paciente : _____

Hospital Name/Norbre del hospital : _____

Date of Examination/Fecha del examen: _____

Examining Practitioner/Médico que practicó el examen: _____

With your consent, a number of specimens were collected from you to provide evidence in court should the case be prosecuted. You may call _____ at _____ to discuss the release of disposition of the sexual offense evidence collected today. Additional tests were conducted as follows:

Usted dio su autorización para que le sacaran muestras de laboratorio que, en caso de jucio, se presentarán como prueba ante lost tribunales. Usted puded llamar a _____ al _____ para hablar sobre la presentación o entrega de la muestra que le sacaron hoy como prueba del delito sexual. Además, le hicieron las siguientes pruebas :

			Yes/Si	No
1.	A blood test for syphilis/Análisis de sangre para detectar sifilis		☐	☐
2.	A blood test for Hepatitis B/Análisis de sangre para detectar hepatitis B		☐	☐
3.	Smear and culture for:/Frotis y cultivo de:	Gonorrhea/Gonorrea	☐	☐
		Chlamydia/Clamidia	☐	☐
		Trichomonas/Tricomonas	☐	☐
4.	Other (specify)/Otras pruebas (indicar)			

You were given medication as follows:/Le dieron lost siguientes medicamentos:

Name of medication/Nombre del medicamento	Dosage/Dosis	For/Por

Remarks:/Observaciones: _____

You were not given any treatment medication because/No le hicieron tratamiento con medicamentos porque:

_____

_____

You were given information/referrals for the following:/Le dieron la siguiente información/referencias:

	Agency/Agencia	Number/Numero
Rape Crisis Counseling/Apoyo psicológico por violación		
HIV/AIDS counseling and Testing/Apoyo psicológico y Para detectar el VIH/SIDA		
Crime Victims Compensation/Compensación a las Victimas de crimenes		
Other/Otras agencies		

An appointment was made for you at this hospital for follow-up medical treatment on _____ (date).
Le dieron una hora en este hospital para el tratamiento médico subsiguiente el _____ (fecha).

An appointment was made for you at this hospital for follow-up counseling on _____ (date).
Le dieron una hora en este hospital para la sesión de apoyo psicológico subsiguiente el _____ (fecha).

_____
(Health Practioner Signature)/(Firma del profesional de la salud)

I have received this Patient Information Form/He recibido este formulario de información sobre el paciente.

_____
(Patient/Parent/Guardian Signature)/(Firma del paciente/padre/madre/tutor)

I do not wish to receive this form./No deseo recibir este formulario.

_____
(Patient/Parent/Guardian Signature)/(Firma del paciente/padre/madre/tutor)

Distribute one copy to patient/Entregue una copia al paciente.
File one copy in Medical Record/Archive una copia en la historia clinica

APPENDIX Q - 3

Print Name or Use Patient Plate

MEDICAL RECORD SEXUAL ASSAULT FORM

I. HISTORY **DATE OF VISIT** _____ **TIME** _____

Significant past medical history: _____

_____

Approximate Time of Attack _____ Is patient pregnant? ____ LMP _____ Medications _____

Allergies _____

Date of Attack _____ Usual form of birth control _____

Is patient bleeding from an injury? Yes _____ No _____

If yes, describe location: _____

_____

II. PHYSICAL EXAMINATION (Note all evidence/details of trauma): _____

_____

_____

III. PELVIC/GENITOURINARY EXAM

Ext/BUS/Hymen _____ Cervix _____ Adnexae _____ Vagina _____ Uterus _____ Rectal _____

Penis _____ Scrotum _____

IV. DIAGNOSTIC TESTS

Pregnancy test _____ GC Cultures _____ (Pharyngeal _____ Cervical _____ Urethral _____

Rectal _____) VDRL _____ Chlamydia ____ Hepatitis B _____ Other _____

V. TREATMENT

Tetanus Toxoid _____ Pregnancy Prevention _____ STI Prophylaxis _ Other _____

VI. EVIDENCE COLLECTION

Evidence collected? Y__ N ____ Evidence kit released to law enforcement? Y _____ N ____

Written consent? Y ____ N ____

VII. FOLLOW UP APPOINTMENT

1. Medical: (Adults should be seen within 2 weeks) 2. Counseling:

Examining Health Practitioner:

_____
Signature

_____
Print Name

Health Practitioner:

_____
Signature

_____
Print Name